



Government of
Saskatchewan



Our Children. Our Promise. Our Future.

Early Childhood Development Annual Report 2001/2002

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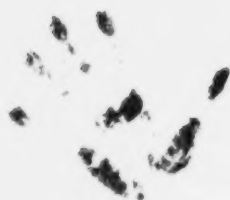
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KidsFirst



national
children's agenda





Executive Summary

The Government of Saskatchewan is pleased to present its first annual Progress Report on Early Childhood Development (ECD). This Report fulfills Saskatchewan's commitment to report publicly on ECD programs and services developed under the First Ministers' ECD Agreement¹, and on indicators of child well-being in Saskatchewan.

Since the unveiling of *Saskatchewan's Action Plan for Children* in 1993, the Government of Saskatchewan has placed increasing emphasis on early childhood development to ensure a good start for vulnerable children, and to improve the capacity of families and communities to support children.

Much has been learned in recent years about the underlying causes of poor developmental outcomes for children. In Saskatchewan, this knowledge has contributed to better identification and targeting of strategies and resources. The *KidsFirst* program is, therefore, focused on children under six who are most vulnerable and their families. Pregnant women living in circumstances of risk are also targeted in an attempt to reduce Fetal Alcohol Syndrome/Fetal Alcohol Effects.

In 2001, Saskatchewan announced more than \$1.7 million in program enhancements for early childhood intervention, the infant mortality initiative, childcare and early learning. In addition, the province launched the cornerstone of the Saskatchewan ECD strategy – *KidsFirst*.

During the first year of *KidsFirst*, \$3.1 million of development funding was provided to nine *KidsFirst* sites in Saskatchewan. An additional \$1.5 M was provided for program support, and home visitor training, system development and to non-targeted communities.

This report also provides general information about Saskatchewan's ECD initiatives as well as specific information about the *KidsFirst* principles, objectives and programs. A more complete reporting on program impacts will be made in the next annual report.

This report contains data on 23 indicators of child well-being for Saskatchewan and Canada. These measures provide a useful baseline for future trend analysis. New data will be available on these indicators every two years. This data will provide an ongoing measure of how well children in Saskatchewan are doing.

Saskatchewan is either consistent with, or can be favourably compared to, the national average on many of the indicators. There are some areas however, that are a challenge — a higher incidence of infant mortality, low birth weight, and smoking rates of pregnant women in Saskatchewan when compared to the Canadian average.

While these issues are of concern, it is important to examine the data in context. For example, with some key indicators, such as birth weight and infant mortality, there has been a stable, long-term trend to improvements in these rates. It is concern over these negative indicators that, in part, spurred the province's interest in the ECD initiative and *KidsFirst*. These measures provide a useful baseline for future trend analysis and over the long term provide some indication of effective program outcomes.

Saskatchewan will remain active in its commitment to having a positive impact on young children and their families as we continue to explore new opportunities for partnership and program growth.

¹ In September 2000, Canada's First Ministers issued an Early Childhood Development Communiqué outlining the commitment of federal, provincial and territorial governments to work together to address the early development needs of all Canadian children. As part of the Early Childhood Development Agreement, First Ministers also committed to report regularly on expenditures and progress under the initiative, and on the measures of child well being in their respective jurisdictions. This is Saskatchewan's second Annual Report on ECD, and the first that reports on ECD progress since the First Ministers' announcement.

Our Children

Overview

The Government of Saskatchewan has been promoting a holistic, community-based approach to meeting the needs of children and families since the introduction of *Saskatchewan's Action Plan for Children* in 1993. Experience with the *Action Plan* increased awareness of the early childhood needs of children and families in the province.

In 1997, the Government identified early childhood development as one of five social priorities for the province and assigned responsibility for the development of an Early Childhood Development (ECD) Strategy to the Ministers of Health, Learning and Social Services.

In 1999, a public discussion paper entitled, *"Building on Community Success — Creating a Long Term Plan for Saskatchewan's Youngest Children and Their Families"* was released. It was clear from the response to the discussion paper that early childhood development was a public concern and that it was time to focus renewed attention on this issue. An ECD Strategy was approved in June 2000.

In September 2000, First Ministers from across the country met and agreed upon a joint ECD framework. Their commitment to the nation's children is reflected in the Communiqué released following that meeting:

"First Ministers affirm their commitment to the well-being of children by setting out their vision of early childhood development as an investment in the future of Canada. Canada's future social vitality and economic prosperity depends on the opportunities that are provided to children today."

As a result of this meeting, First Ministers committed their governments to strengthening their ECD programming and, in return, the federal government agreed to commit additional funding to support this work. As part of this

commitment, the Government of Canada agreed to transfer approximately \$73 million to Saskatchewan over five years, beginning in 2001 – 2002. This commitment, and the new funding, accelerated Saskatchewan progress on ECD initiatives. In April 2001, *KidsFirst*, a cornerstone of the Province's ECD strategy, was announced.

An effective response to early childhood needs requires the cooperation of the health, social services and education systems. A management team, made up of representatives from the Government's Human Services Integration Forum, as well as from the Departments of Learning, Social Services, Health, and Government Relations and Aboriginal Affairs, oversees development and implementation of the strategy. Implementation of *KidsFirst* is underway and additional funds have been directed to children with special needs, child day care, pre-kindergarten programs, and to programs aimed at reducing infant mortality in targeted communities.

During the first year, work focused largely on community consultation and on development and implementation of ECD initiatives. Eight communities in the south (Meadow Lake, Moose Jaw, Nipawin, North Battleford, Prince Albert, Regina, Saskatoon and Yorkton) and all of the North received funds to implement *KidsFirst*. Outside of these targeted communities, early childhood community development workers are working with community partners to improve awareness of the needs of high-risk families and realign services to more effectively respond to these families.

This Annual Report outlines the progress made during 2001-02. It is the second in a series of annual reports which will help to inform the public about Saskatchewan's ECD strategy and the efforts of communities to ensure that vulnerable children get a good start in life.

Making A Difference

In Canada and around the world, there is a growing understanding of the importance of early childhood and how the quality of care received in the first three to six years of life can influence the level of success and well-being an individual experiences throughout his or her lifetime.

It is now widely recognized that the parenting style, health status and lifestyle of parents have a great impact on how well children grow and develop. The reality is, however, that mothers and fathers are sometimes unprepared for parenthood and lack the knowledge and support they need to successfully fulfill their role as parents.

For any child, a healthy start in life begins with regular prenatal care and good nutrition on the part of the mother, including abstaining from alcohol and other drugs. Since full-term pregnancies and healthy birth weights give babies the best start in life, it is important that pregnant women be encouraged and supported to eat a nutritious and balanced diet and to do all they can to ensure a healthy baby.

Recent research reinforces the importance of a secure attachment to a trusted caregiver (parent or other adult) to the healthy development of infants and young children. This individual, usually the mother, is someone the child can count on to provide predictable, consistent care, support and affection. Substance abuse, abandonment by a partner, or a caregiver who is depressed can lead to an inability to form a secure attachment between caregiver and child. A child who is neglected early in its life will require more people to demonstrate and provide a caring environment and more opportunities to build relationships than a child who has learned from birth that adults provide comfort and love.

Effective parenting practices, along with family stability, security and close, warm and supportive relationships are also important factors in ensuring that a child meets important early childhood development milestones. Positive parenting has been shown to reduce the chances of developmental problems in children by 25 to 52 per cent, depending upon the nature of the problem.

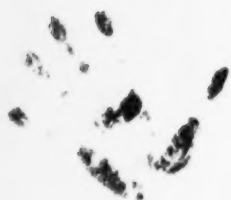
Changes in Canada's social and economic environment have resulted in changing family structures and characteristics. Today, almost 70 per cent of Saskatchewan parents of young children work or attend school, which means their children are cared for by someone other than a parent.

Child care is provided in a number of different ways. In Saskatchewan less than 10 per cent of child care is provided by licensed child care providers. The remainder is monitored solely by parents. In these situations it is important that parents have good information about the child care needs of their children.

Quality child care — provided by people who are knowledgeable about child development, with limits on the number and ages of children being cared for and a program which provides age-appropriate activities — is associated with better outcomes, including better social and language skills. Child care that lacks these characteristics tends to be associated with an increased incidence of behaviour problems, poor social skills, delayed language development, and less-developed school-readiness skills.

"There is powerful new evidence from neuroscience that the early years of development from conception to age six, particularly for the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life."

"The Early Years Study" Mustard and McCain, 1999

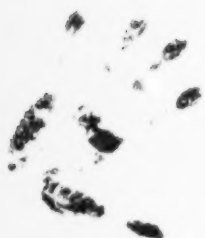


Some children, because of their family's social and/or economic circumstances or poor parenting skills, do not live in a safe, nurturing and stimulating environment. Lack of appropriate nurturing, stimulation and physical care in the early years can result in problems with cognitive, emotional, physical and social development. Early intervention is the most effective means of addressing children's needs and results in the most significant benefit over the long term, including improved school performance, higher educational attainment, increased likelihood of regular employment, improved social skills, better health and less likelihood of becoming involved in the criminal justice system.



The exact extent to which Saskatchewan children and their families live in circumstances which make them vulnerable is not known. We do know, however, that children from low-income families are more likely than children in higher-income families to:

- live in substandard housing, problem neighbourhoods, and poorly-functioning families;
- demonstrate higher levels of aggression;
- suffer from health problems and delayed development; and,
- have fewer opportunities to take part in cultural and recreational activities.



Research clearly identified several characteristics shared by effective interventions:

- They require an individualized approach based on the specific needs of the children and families being served;
- To have the greatest impact, services should be family-centered, community-based and provided in a coordinated manner; and,
- Interventions up to or before age three have been shown to have the greatest impact on early school achievement and social skills.

Other factors which have been linked to healthy child development and school readiness include:

- healthy birth weight;
- strong parenting skills;
- a nurturing and stimulating environment;
- safe neighbourhoods;
- high-quality child care;
- a community that provides the child with opportunities to learn, become involved in recreational activities, and develop social skills;
- good health care; and,
- access to information about such things as nutrition and caregiver-child bonding.

Saskatchewan has been guided by this research in the development of our ECD strategy.

In addition to research we recognize the need to learn from our experience. To do this, there is a need to track the health and progress of the province's children. Saskatchewan has agreed to regularly report on a set of common indicators of child well-being. More details of these indicators can be found in Appendices B and C attached to this report.



Our Promise

Saskatchewan's ECD Strategy

Since 1993, the Province has taken a comprehensive, coordinated approach to children's issues through the *Saskatchewan Action Plan for Children*. With the formal identification of early childhood as a provincial priority in 1997, the Saskatchewan government began to focus on the development of a comprehensive ECD strategy. In April 2001, the Government announced a \$1.7 million increase in funding to enhance existing ECD-related programs.

- Approximately \$500,000 was directed to existing child care programs to improve wages for child care workers.
- Another \$500,000 was targeted to the child care sector to provide additional training for child care staff, to enable them to enhance the quality of developmental programs available in child care centres.
- To strengthen the ability to respond to children with special needs, an additional \$400,000 was invested to create 104 spaces in the Early Childhood Intervention Program.
- \$200,000 was directed to the enhancement of pre-Kindergarten programming in four communities to improve the readiness of vulnerable children for learning.
- Three high risk communities were provided with funding totalling \$95,000 to develop innovative programs to address issues related to infant mortality.

In addition to these funding increases, significant development work was undertaken on the *KidsFirst* program. Saskatchewan's approach is community-based, involving collaboration with health districts, school divisions, Aboriginal organizations and other community partners. *KidsFirst* was officially launched in April 2001.

KidsFirst

The purpose of the *KidsFirst* program is to support vulnerable families in developing the capacity to nurture their children.

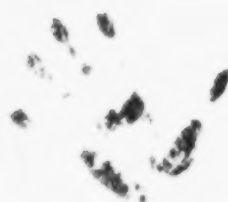
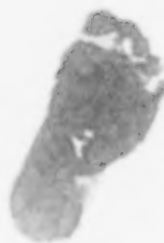
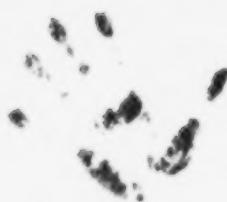
The program focuses on services for children, prenatal to age five, and their families, who are most vulnerable due to their social and economic circumstances. Emphasis is also placed on prevention of Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/E).

KidsFirst services are targeted, to a significant degree, to low-income neighbourhoods and communities. In addition, in recognition of Saskatchewan's rapidly growing Aboriginal population, and the social challenges facing many Aboriginal communities, all early childhood initiatives in Saskatchewan emphasize the involvement of Aboriginal people and organizations to ensure services are culturally relevant.

Saskatchewan has taken a community partnership approach to the development and implementation of *KidsFirst*. At the outset, major stakeholders in each community were invited to become part of the planning process for their local *KidsFirst* program. This process evolved into the use of a sub-committee structure, through which specific components of the program could be developed. Program components have been assumed by a variety of existing agencies, which are working in partnership to provide comprehensive, integrated early childhood services. Although this collaborative model has delayed implementation in some cases, it has strengthened existing partnerships, built new ones and solidified support for the program at the local level.

KidsFirst Vision

Vulnerable children enjoy a good start in life and are nurtured and supported by caring families and communities. In targeted high-needs communities, supports and services are provided through partnerships between families, communities, service organizations and governments.



Management of the *KidsFirst* program is shared by the provincial government and the communities receiving *KidsFirst* funding. Each community has established a *KidsFirst* Management Committee and has selected either a local school division or health district as the accountable partner. The government is responsible for setting policy and program direction, allocating funding, approving community plans, establishing an accountability framework and reporting publicly on expenditures and progress of the program. The local accountable partner, working in partnership with the *KidsFirst* management committee, is responsible for the development and implementation of the *KidsFirst* program at the local level, within the framework provided by the province. Local partners are also accountable to government for reporting on progress and expenditures for the program.

At a minimum, the local *KidsFirst* management committees are made up of representatives from the health district, school division, regional Social Services office, and First Nations and Métis organizations. Typically, local management committees have a much broader membership and have included representatives from a variety of stakeholder groups.

To oversee the planning, coordination and management of *KidsFirst* locally, program managers have been hired in each of the communities. They have been working with local planning committees to plan and develop the program within each community. Representatives at these tables come from stakeholder groups that have a vested interest in early childhood development, including community-based organizations that have become directly involved in program delivery.

The majority of federal funding for early childhood development has been committed to the *KidsFirst* program. The program components are:

- Prenatal casefinding focused on prevention of FAS/E;
- A universal, hospital-based screening program for newborns and their families;
- An intensive home visiting program;
- Enhanced early learning opportunities;
- Increased access to child care;
- Dedicated mental health and addiction treatment services; and,
- A range of community supports including literacy, parenting and nutrition.

KidsFirst Principles

Services are strength based, focusing on partnership with the parents, their wants and needs, and their strengths and capacities.

Participation in the program is voluntary.

Aboriginal organizations are included in the development and implementation of the program to ensure that programs offered are culturally appropriate.

The program utilizes existing community programs and services, to ensure that the program develops in an intersectoral and integrated manner.

Programs are innovative and flexible to respond to the needs of the families.

First Ministers agreed they would take action in four key areas. What follows is a brief description of Saskatchewan programming as it relates to each area of action.

Promote Healthy Pregnancy, Birth and Infancy

Prenatal, birth and infancy experiences have a profound effect on the health and well-being of infants and young children, and contribute to continuing good health. This priority addresses needs related to the prenatal, birth and infancy periods and includes supports for pregnant women, new parents, infants and care providers.

The *Kidsl'irst* program places a strong emphasis on healthy pregnancy, birth and infancy. One component of the program is aimed at early identification of pregnant women who are at risk of having poor birth outcomes due to ongoing use of alcohol and/or drugs. These women are then supported through a home visiting program which provides nutritional supports, prenatal education, and transportation to required prenatal services. Additional services include ready access to dedicated mental health and addictions services.

The issue of infant mortality is of concern across the country. In Saskatchewan, a portion of the federal funding was directed to three high needs communities to develop new initiatives to support healthy pregnancy and birth. These communities have generally chosen to leverage this money by working with the *Kidsl'irst* program in these areas.

Improve Parenting and Family Supports

Parents and families have the primary responsibility for the care of their children. This priority addresses the needs related to positive parenting and includes supports for parents and caregivers.

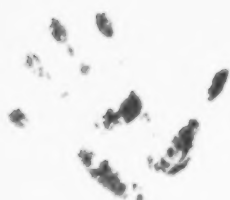
The Early Childhood Intervention Program (ECIP) in Saskatchewan provides home-based supports to families with children who have special needs. ECIP has been enhanced to provide additional support to 104 more families with special needs children.

The *Kidsl'irst* program also has several components which address this key area. Through the home visiting program, staff provide information to strengthen parenting skills. This could involve direct one-on-one coaching in parenting skills or the involvement of the parent in community-based parent education programs.

Many of the families involved in the *Kidsl'irst* program have limited social support networks. One of the objectives of the *Kidsl'irst* program is to strengthen the social support networks for these families. Through a variety of approaches, parents are connected to opportunities within communities. In some cases, new support networks are being developed and tailored to the need of these parents. This might involve community kitchen groups, parent support groups, literacy programs, and a range of other related supports.

Parents in the *Kidsl'irst* program may need to access child care services so they can attend to their own health needs or so they can improve their literacy, employment or other skills. Availability of quality child care will allow them the opportunity to do so. The more skills and abilities a parent can develop to enhance their self-esteem and self-worth, the better able they will be to nurture their children.





Strengthen Early Childhood Development, Learning and Care

Quality early childhood learning and care programs have been shown to promote physical, language and motor skills, and social, emotional and cognitive development. This priority includes supports that promote healthy development, provide opportunities for interaction and play, help prepare children for school and respond to the diverse and changing needs of families.

Child care staff are committed to quality care which nurtures child development. Through the enhancement of wages and training for staff, their retention in the child care system will be improved and their ability to provide appropriate developmental activities in a child care setting will be strengthened.

Additional funding for the pre-Kindergarten program will expand the ability of Saskatchewan school divisions to engage high-risk children in early educational activities to improve their readiness to learn upon normal school entry.

Most of the components of the *Kidstfirst* program work together to ensure children are able to achieve developmental milestones, interact with other children, develop good social skills and go to school ready to learn.

The home visiting program will work with parents to enhance their parenting skills and provide appropriate support to their children to develop well. Within the *Kidstfirst* program, new child care and early learning programs are being developed to ensure the families involved have access to these supports when needed. Through the development of quality

child care and early learning programs, children's access to good stimulating activities that enhance their development will be strengthened.

Strengthen Community Supports

Strong communities contribute to the well-being of children through formal and informal networks. This priority includes supports to strengthen community capacity to meet the needs of children and families from a healthy community perspective.

Saskatchewan communities have a rich history of working together for the benefit of their citizens. The use of the community development approach has resulted in strengthened and new partnerships within communities. Working together with families, community organizations and governments, communities have developed innovative approaches to serving families facing significant challenges. Networks among agencies and families have developed or solidified, enabling communities to better respond to the needs of their most challenged families.

Following is a chart which indicates the status of implementation of the various components of the *Kidstfirst* program as of March 31, 2002.

Program Component	Status of Implementation (March 31, 2002)
In-hospital screening of newborns and their families	Implemented in 7 of 9 communities
Assessments of identified families	Implemented in 4 of 9 communities
Prenatal program for high-risk pregnant women	Implemented in 6 of 9 communities
Home visiting program	Implemented in 3 of 9 communities
Child care spaces	47 new child care spaces established
Early learning	Under development in all communities
Parent support programs	Implemented in 2 of 9 communities
Mental health and addictions program	Implemented in 3 of 9 communities

While the KidsFirst program is still in its infancy, anecdotal evidence shows the program is already making a difference.

Involving pregnant women in *KidsFirst* programs was considered to be one of the biggest challenges. However, by using existing community programs and working closely with the various Canada Prenatal Nutrition Programs, the program staff made significant progress, and the participation of high-risk pregnant women in *KidsFirst* has greatly exceeded initial projections.

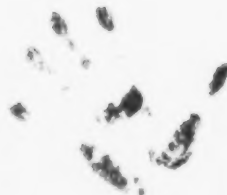
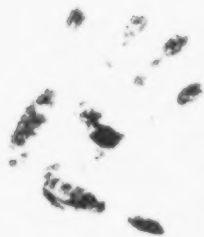
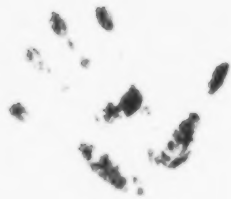
Group activities have also proven to be of positive benefit in promoting the development of supportive friendships between program participants. Families involved in group activities have initiated exchange programs to share children's clothing and toys, set up coffee groups to share information and experiences and requested facilitated discussions about substantive issues, such as personal relationships and family violence.

Program staff report noticeable improvements in attachment between children and parents who participate together in group activity sessions. Programs focused on parent /child literacy have led to requests by some parents for programs aimed at improving their own literacy skills. In addition, several communities have initiated discussions with local housing authorities, and have begun developing plans to improve housing for *KidsFirst* families.

Many more families in *KidsFirst* communities are accessing needed mental health and addictions services. From the perspective of participants, the relevance of the *KidsFirst* program is illustrated by the fact that a number of families who needed to relocate cited access to the program as a requirement in their new community.

The *KidsFirst* program has engaged numerous partners, such as school divisions and health authorities, in focusing on early childhood as a priority. As a result, community partners are more effectively and consistently addressing the question of what they, as a community, can do to strengthen services for families and their children.





KidsFirst Goals and Objectives

Goal 1: High risk children are born and remain healthy.

KidsFirst supports high risk pregnant woman to access appropriate prenatal care to reduce the impact of mental health or addictions issues on the developing fetus. The program also supports families to access routine preventative health services while their children are young.

Objective 1—Improved prenatal care and support for pregnant women in the program.

Objective 2—Primary caregivers assist pregnant women in addressing their mental health and addictions issues.

Objective 3—Children maintain good physical health status or improved health status over time.

Goal 2: High risk children are supported and nurtured by healthy, well-functioning families.

Childhood outcomes are strongly influenced by the health and functioning of the family in which they grow up. By assisting parents to address issues such as housing, education, and social relationships, families will be in a better position to support the development of their children.

Objective 1—Social support networks, housing, food security (availability), education, employment, and income for families will improve over time.

Objective 2—Families' social and emotional health is maintained or improves over time.

Objective 3—Families develop and maintain a safe and secure home environment.

Goal 3: High risk children are supported to maximize their ability to learn, thrive and problem solve within their inherent capacity.

Encouraging stimulating environments, play-based learning, and identifying and supporting *KidsFirst* children with special needs, promotes healthy cognitive development. Research indicates the importance of integrating early learning, childcare and parenting support elements to improve children's abilities to learn. Some families identify structured care and learning environments outside the home as an initial necessary support while addressing their own social or economic challenges.

Objective 1—Improve children's abilities to learn.

Goal 4: High risk children and families are appropriately served by KidsFirst programs and supports.

This goal relates to the program's effectiveness and efficiency. The following objectives pertain to the performance of the program in meeting needs and achieving objectives, rather than to objectives pertaining to client progress.

Objective 1—Establish and maintain shared accountability mechanisms for processes and outcomes.

Objective 2—Create and maintain a service system for early childhood development that uses a community development approach, is built on existing services, and is integrated, comprehensive, innovative, flexible and inclusive.

Objective 3—Identify appropriate families in a timely manner and retain them in the program.

Objective 4—Families are satisfied with *KidsFirst* services.

Our Future

Measuring Progress

In addition to measuring children's progress through the indicators of child well-being, it is important to evaluate the impact of programs on our efforts to improve the lives of young children. Strong programs are holistic and integrated, resulting in a range of comprehensive and interdependent services for families. While we know that this approach works best, it is difficult to develop direct methods to measure the impact of our actions.

Program indicators can be used to track program impacts, identify opportunities for improvement, and demonstrate effective performance by:

- Providing baseline data to establish planning priorities;
- Assessing progress towards the achievement of goals and targets;
- Identifying areas requiring further attention; and,
- Monitoring the effects of implementing change.

The Government of Saskatchewan is currently developing methods of measuring the impact of participating in the *KidsFirst* program on children and families and will report on these measures in the future.

KidsFirst is addressing access, affordability, and quality by requiring programs in each of the targeted communities to:

- Make home visiting, child care, and early learning programs available at no cost to families;
- Monitor the quality of early learning and care programs;
- Provide child care spaces and early learning opportunities exclusively for *KidsFirst* families;
- Provide transportation, child care, and other services to support family participation in programs;
- Provide mental health and addiction services exclusively to *KidsFirst* families; and,

- Ensure that services to families are provided in a holistic, integrated manner.

Community development is a time-consuming process. Measurements and tracking systems are currently in development so that future reports can provide information on progress of children and families in the program as well as the efficiency and effectiveness of the program.

The Path Forward

2001-02 was a developmental year for the Province's new initiatives. Considerable time was spent determining the best use of resources, and implementing the various components of the Government's plans for early childhood.

In 2002-03, supports for child care wages and training enhancements will continue, as will support for the Early Childhood Intervention Program, infant mortality initiatives and pre-Kindergarten enhancements. Full implementation of all *KidsFirst* program elements in targeted communities will be completed by September 2002.

Other work to be undertaken in the 2002-03 fiscal year includes:

- Implementation of tools to monitor child and family progress in *KidsFirst*;
- Development of a provincial performance measurement and management system; and,
- Ongoing development of staff training programs, offered both centrally and in local communities to ensure consistency of approach across the province and to ensure staff have the skills and tools necessary to support families and children.

The 2002-03 fiscal year will be the first fully operational year for the *KidsFirst* program. Those involved in the program are excited to reach this goal, so they can begin to watch the families and their children reap the benefits of the new supports.

Appendix A

Summary of Investments — 2001-02

Implementation of Saskatchewan's ECD initiative has been greatly aided by the transfer of federal funding to the province. Through the First Ministers Initiative, federal and provincial governments have made a joint commitment to support families and communities in their efforts to ensure the best possible future for their children.

The foundation of Saskatchewan's ECD Strategy is community engagement. Fiscal year 2001-02 was largely a developmental one for the communities that are participating. As a result, program start-ups have occurred at a slower rate

than was originally expected and expenditures were lower than anticipated for the year. It is expected that developmental work will be completed in 2002-03 and program expenditures will increase as community structures become fully operational.

While provincial spending on the ECD initiative for 2001-02 did not equal the federal contribution to Saskatchewan for that year, the Province will ensure that all federal contributions for ECD will be used for the purpose intended.

New investments for 2001-02 were:

Program Area	Expenditure
, KidsFirst	
In non-targeted communities:	\$ 637,000
• Universal newborn screening	
• Realignment of existing programs	
In targeted communities:	\$3,119,000
• Prenatal screening and outreach	
• Screening and assessment	
• Home visiting	
• Mental Health and addictions	
• Enhanced childcare	
• Early learning programs	
• Parenting supports	
Program Support*	\$ 402,000
Home visitor training/Systems Development	\$ 478,000
Child Care	\$1,019,000
• Training, wage enhancement and start-up grants	
Early Intervention Services	\$ 370,000
Pre-Kindergarten Programs	\$ 200,000
Infant Mortality Initiative	\$ 95,000
TOTAL	\$6,320,000

A more complete summary of the early childhood development programming that was available in the province prior to the start of the First Ministers' Initiative is available in the baseline report that was released in June 2002 (Update on Early Childhood Development 2000/01).

Appendix B

Indicators of Child Well-Being in Saskatchewan

The primary influences on children occur within families. Families in turn are shaped by the physical and community environments in which they live. The linkage between physical surroundings and children's health and well-being, has been observed for years. Research is providing evidence that growing up in a community that is perceived to have higher levels of cohesion, stability and social supports will lead to healthier child development. A growing number of comparable indicators are

now becoming available for governments to use in a number of areas of interest — physical health, early development, safety and security, as well as family and community well being.

First Ministers agreed to make regular public reports on indicators of child well-being using an agreed upon set of indicators. Saskatchewan has chosen to report on 23 indicators of child well-being.

The Early Childhood Development Agreement – Common Indicators of Child Well-Being

Physical Health

- Healthy birth weight – high or low
- Immunization – meningococcal disease
- Immunization – measles
- Immunization – haemophilus influenza b (Hib)
- Infant mortality rate
- Pre-term birth rate
- Breastfeeding

Early Development, including social and emotional development

- Physical health and motor development
- Emotional problem/anxiety
- Hyperactivity/inattention
- Physical aggression/conduct problem
- Prosocial behaviour
- Language skills

Safety and Security

- Injury mortality rate
- Injury hospitalization rate

Family

- Parental education
- Level of income
- Parental depression
- Tobacco use in pregnancy
- Family functioning
- Positive parenting
- Reading by adult

Community

- Neighbourhood satisfaction, safety, cohesion

Saskatchewan is either consistent with, or can be favourably compared to, the national average in many areas (i.e. pre-term birth weight, breastfeeding). There are some indicators however, that are of concern. For example, there is a higher incidence of infant mortality, and smoking rates of pregnant women in Saskatchewan when compared to the Canadian

average. Public health analysts monitoring this data have been highlighting these concerns for several years. It was concern over these negative indicators that, in part, spurred the province's interest in the ECD initiative and created the long-term preventive vision contained in *KidsFirst*.

Within the context of a Canada-wide Early Childhood Development initiative, this inaugural report represents the beginning of a comprehensive monitoring system of child well-being in Saskatchewan. What is being presented is one (or in some cases two) year's data, and the time period precedes the Saskatchewan and federal ECD Initiative by two years.

Nevertheless, these indicators provide a useful baseline for future trend analysis. New data will be available on these indicators every two years. This data will provide an ongoing measure of how well children in Saskatchewan and Canada are doing.



While Saskatchewan is weaker on some indicators, there has been a stable, long-term trend to improvement. Both the federal government and Saskatchewan Health have recently released comprehensive reports on comparable health indicators¹. Readers looking for a more detailed description of these trends are directed to these reports.

It is important to note that these are general indicators of child well-being, which are impacted by the overall functioning of a society as well as by the multiplicity of programs available to the population. They are not intended to assess the impact of any particular program.

It is also recognized that some gaps exist in the data. This results in an incomplete picture for some indicators and for some populations of children, most notably Aboriginal children. Efforts are underway to improve data collection for future years.

This Appendix contains charts of baseline measures of Indicators of Child Well-Being. Beginning on page 30, Appendix C provides data definitions and specifications for the indicators. These data compare Saskatchewan and Canada over two years — 1998 and 1999 or at a single point in time in 1998/99. Readers should be mindful of the limitations and the restrictions imposed by the data definitions when interpreting this information.

Physical Health

Five of the seven indicators of Physical Health status included in this report use objective, administrative information gathered from hospitals and physicians. The other two indicators, breast feeding rates and duration of breast feeding, come from survey data gathered from parents or others knowledgeable about their child included in the National Longitudinal Study of Children and Youth.

Of the public health data indicators, healthy birth weight is seen as the key determinant of infant survival. Low birth weight babies are at higher risk of dying in their first year, and have a greater risk of disability and chronic medical difficulties in later life. Low birth weight is associated with poor maternal health, lifestyle and economic circumstances. High birth weight babies are also at higher risk for early death although the proportion of high birth weight infants who die is a fraction of the mortality rate of low weight infants.

Infectious diseases continue to affect thousands each year, although the mortality rate in all Canadian provinces has declined greatly in recent years because of wide scale immunization programs and greater surveillance by families and health professionals. Tracking the incidence of diseases such as measles, meningococcal disease and haemophilus influenza B provides an indication of periodic outbreaks of these diseases and the extent to which wide scale immunization practices have effect.

The high rate for haemophilus influenza-b relates to a spike for the years shown. The long-term trend shows that we have made great strides in decreasing the incidence of this disease and, except for 1997-98 in particular, are now slightly below the Canadian average.

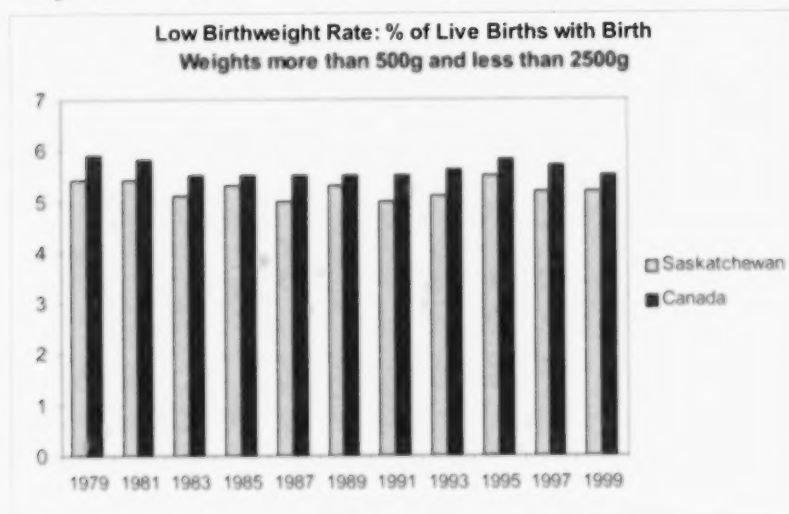
Of all other indicators, infant mortality rates are recognized as one of the most important measures of child and mother health status. A high rate is an indication of deficiencies in nutrition, socio-economic status, education or access to health care. Infant mortality is also strongly linked to maternal factors such as level of education, age, smoking, and drug or alcohol abuse. Over the last 20 years there has been a dramatic and steady decline in infant mortality in all provinces.

In Saskatchewan, the factors most responsible for the high infant mortality rates found are related to infant attributes (e.g. congenital defects, low birth weights, prematurity), as well as maternal characteristics (e.g. smoking, substance abuse, infection and disease during pregnancy, inadequate nutrition, low body weight before pregnancy, low socio-economic status and pregnancy in very young mothers). With the high teen-age pregnancy rate in Saskatchewan, this wields a strong negative influence on infant mortality.

The reason for the higher than national average rate of injury hospitalizations in Saskatchewan is unknown. More research is required to reveal reasons for this rate and programs will need to be developed to address this phenomenon.

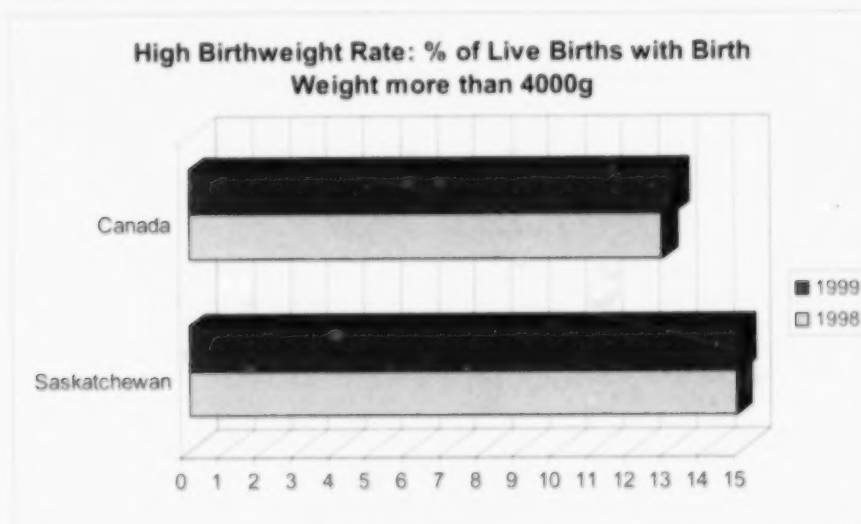
Breast-feeding is recognized as an important contributor to healthy development of infants. The direct benefits of healthy brain and nervous system development and immune system enhancement provided by breast-feeding over an extended period of early childhood are well understood. Breast-feeding is also recognized as an important contributor to healthy emotional development of infants because it improves bonding between infant and mother, as well as improves the development of positive social behaviours.

Physical Health - Chart 1



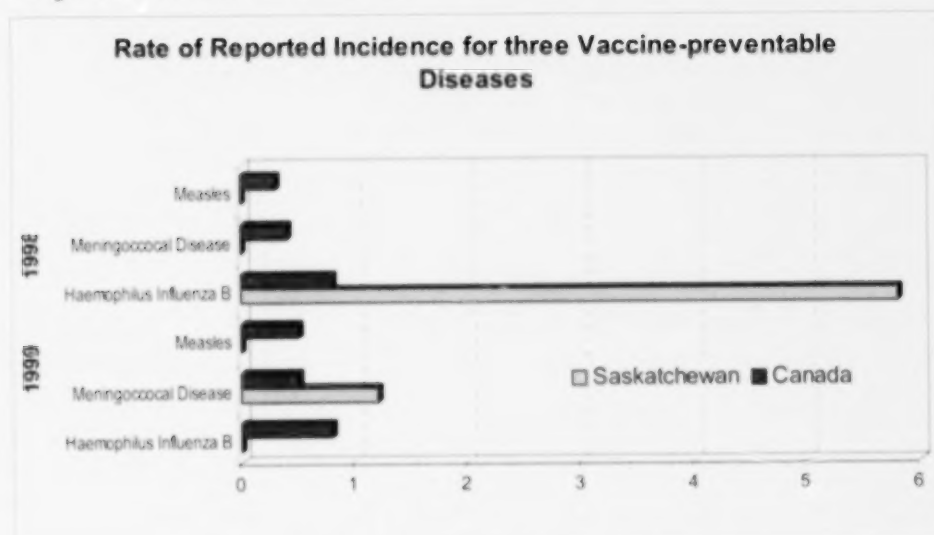
Source: Canada Vital Statistics - Birth Database

Physical Health - Chart 2



Source: Canada Vital Statistics - Birth Database

Physical Health - Chart 3

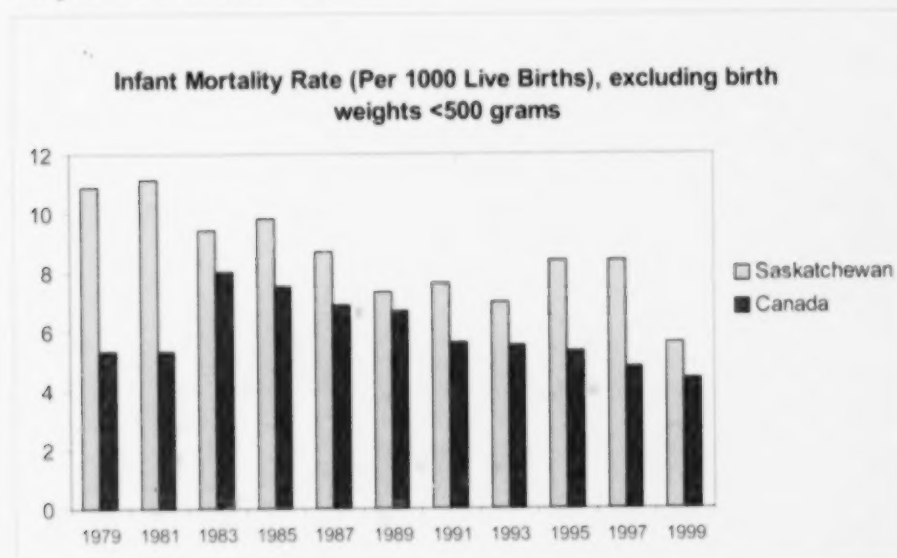


Measles and Meningococcal Disease rates include children 0 to 5 years of age; Haemophilus Influenza B rates include children 0 to 4 years of age.

Source: Division of Immunization and Respiratory Diseases, Health Canada

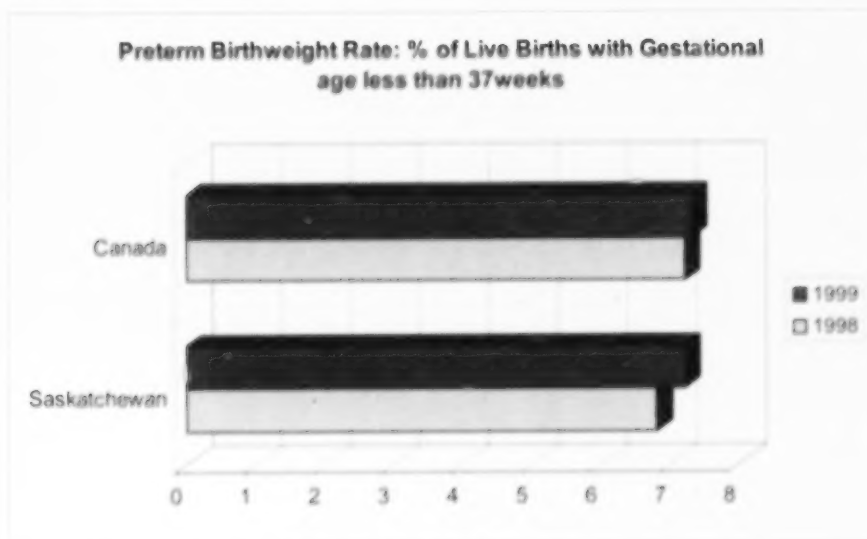
Note: While not shown on the graph, the incidence rate for haemophilus influenzae-b for Saskatchewan has closely followed the Canadian trend from 1992 to 2000 with the exception of 1997-98, where rates increased to 5.65 and 2.90 per 100,000 respectively. Since that time, the Saskatchewan incidence rate is once again comparable to the Canadian rates, with no cases reported in 1999 or 2000.

Physical Health - Chart 4



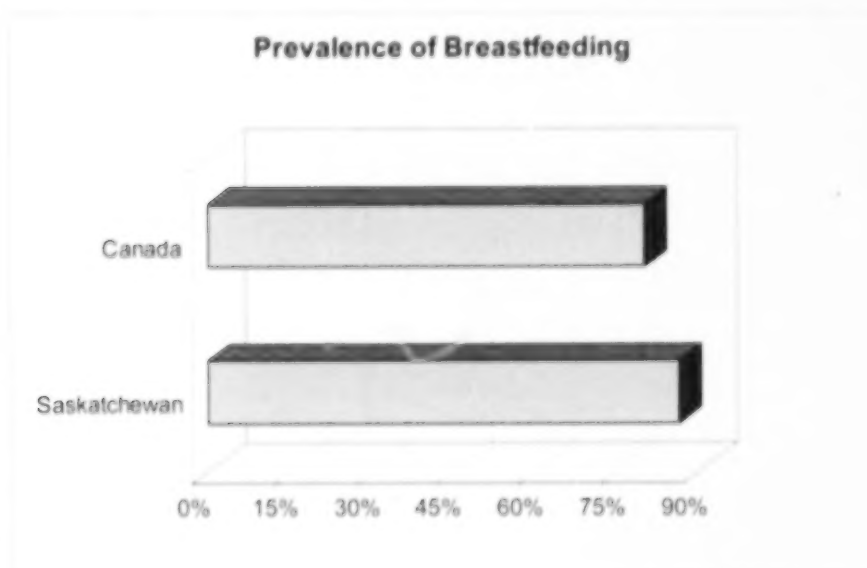
Source: Canadian Vital Statistics - Mortality, Summary List of Causes

Physical Health - Chart 5



Source: Canadian Vital Statistics - Birth Database

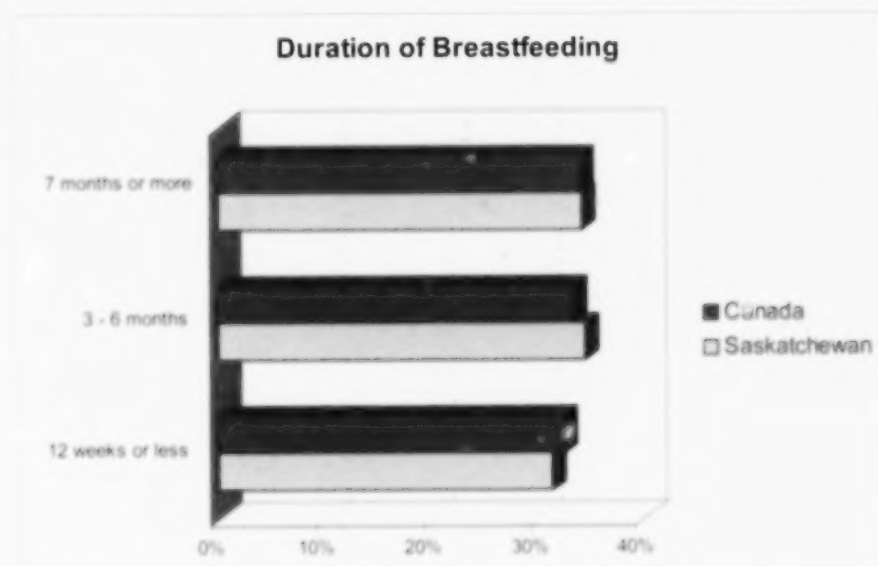
Physical Health - Chart 6



Note: Includes both children currently being breastfed as well as all children who were ever breastfed.

Source: National Longitudinal Study of Children and Youth (NLSCY), Cycle # (1998/99), Master File, Parents Questionnaire; data presented.

Physical Health - Chart 7



Note: Based on standardized score for MSD

Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

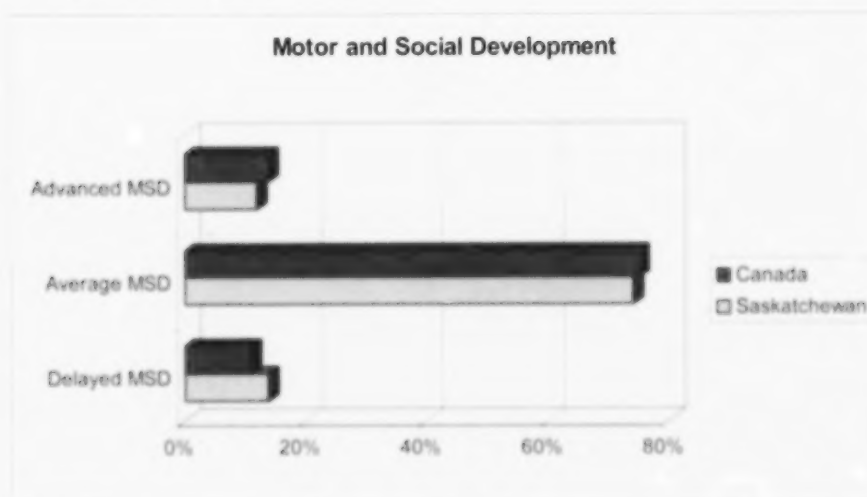
Early Development

Negative childhood behaviours such as low positive social behaviour, aggression, hyperactivity and emotional problems place children at a higher risk for life long difficulties, such as poor educational achievement, involvement with the justice system, violent behaviour as an adult and low socio-economic status. Although the frequency of these negative behaviours is more prevalent in adolescence, significant levels of these behaviours appear in early childhood. There are strong linkages between poor emotional health

in children and weaker parenting styles and family dysfunction.

Scores on the Peabody Picture Vocabulary Test are a good predictor of later school success. In the National Longitudinal Study of Children and Youth, the Peabody test was administered to four and five year old children in the sample and as such, can also provide some indication of school readiness by measuring verbal ability. There are strong linkages between PPVT scores and parenting style and education levels of parents. Socio-economic status is not closely linked to PPVT scores.

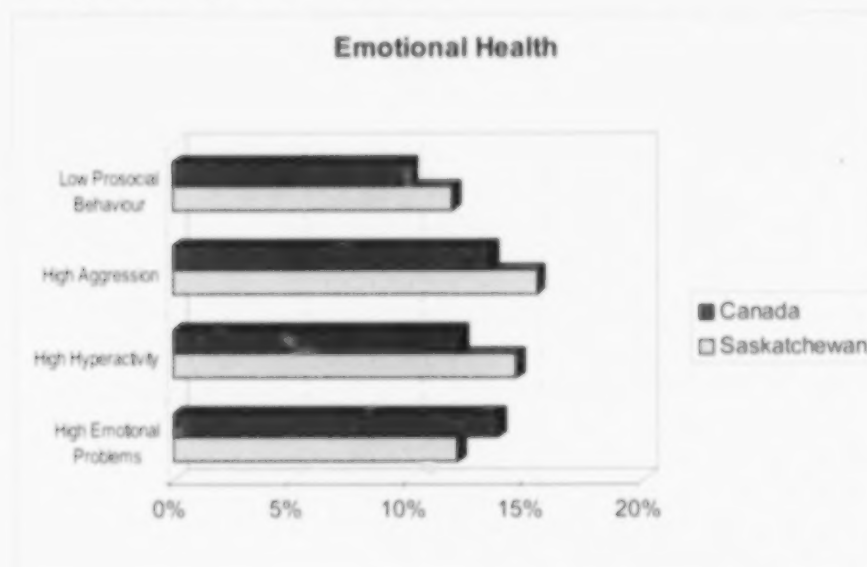
Early Development - Chart 1



NOTE: Based on standardized score for MSD

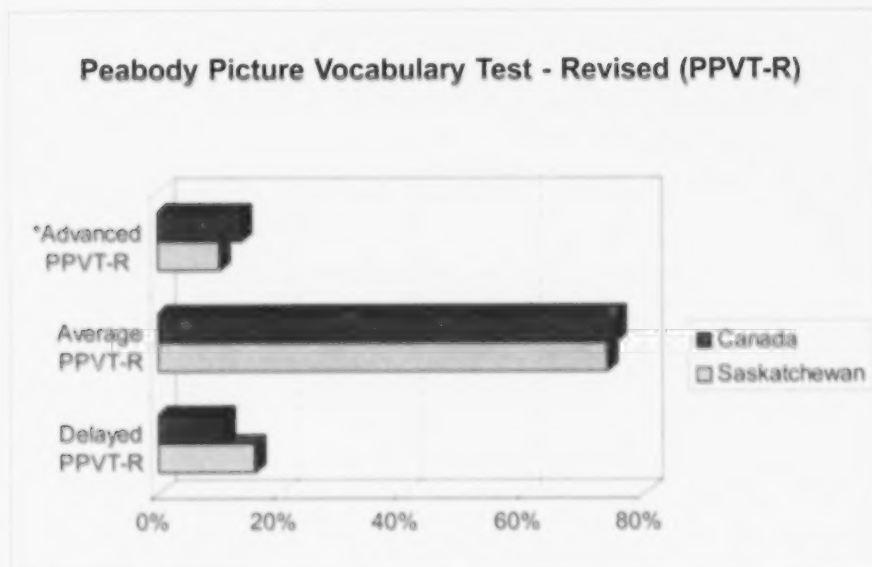
SOURCE: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Early Development - Chart 2



SOURCE: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Early Development - Chart 3



*"Marginal" data quality

Note: Based on standardized score for PPVT-R

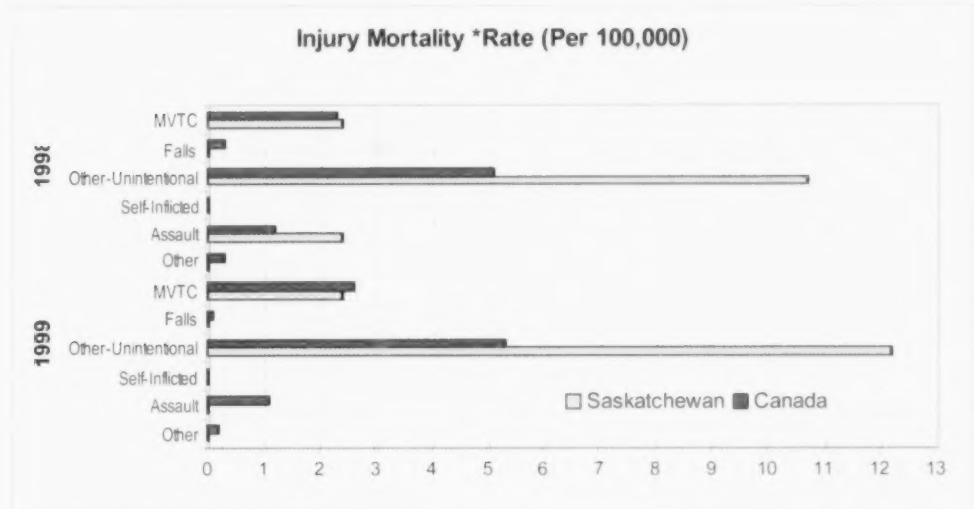
Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented is weighted.

Safety and Security

Injury mortality rate and injury hospitalization rate are public health measures of reported cases of hospitalization or death due to injury. Safety equipment like seat belts in automobiles, helmets for motorcycles and snowmobiles, and lifejackets for watercraft have dramatically reduced injury and death. There is considerable

variation in injury mortality rates across the country that is reflective of differences regionally and locally with respect to such things as lifestyle, such as farming, or ease of access to emergency services in remote areas. Injury rates are also strongly related to income levels, family composition and household size. Rates are highest on Canada's reserves and in poor urban neighbourhoods.

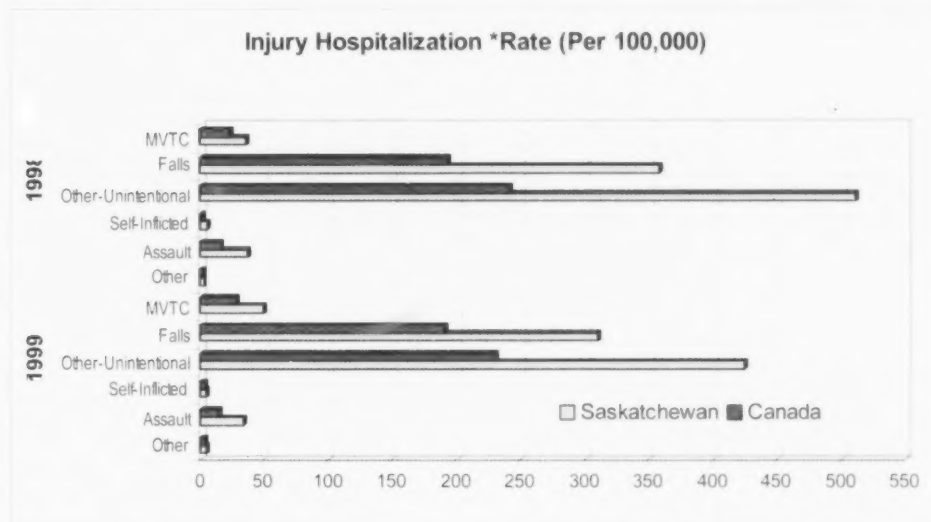
Safety and Security - Chart 1



**Province or Territory of residence used.*

Source: Canadian Vital Statistics - Mortality, Summary List of Causes

Safety and Security - Chart 2



**Province or Territory of residence used.*

Source: Canadian Vital Statistics - Mortality, Summary List of Causes

Family-Related Indicators

While parental educational attainment is linked to many of the indicators of child well being included in this report, researchers have so far been unable to precisely determine how education levels of parents influence child developmental and educational outcomes. Parents with higher education are more likely to hold higher paying jobs, place a higher value on education, and spend more time reading to their children or helping with homework. All these factors contribute to improved educational outcomes. Further study will improve the understanding of the effect of education levels of parents.

Low Income Cut Off Rates (LICO) are income thresholds, determined by analyzing family expenditure data obtained through the Survey of Labour Market and Income Dynamics, which samples information from a large survey of Canadian families. The LICO is the threshold below which families will likely devote a larger share of their income to the basic necessities of food, shelter and clothing than the average family would. LICOs are often, mistakenly, referred to as poverty lines. There is no official designation of LICOs as such. Because LICOs are relative measures of all income levels, considerable variation can occur from year to year.

Tobacco use is the leading cause of preventable illness and death in Canada. While second hand smoke is a serious health risk for everyone, fetuses and young children are particularly susceptible to the harmful effects of tobacco smoke in their environment. These effects include stillbirth, low birth weight, increased risk of sudden infant death syndrome, reduced lung development and increased incidence and severity of respiratory illness. Reducing the

number of women who smoke during pregnancy is an important public health objective. Smoking rates are highest among young women, poor people and those in remote communities. Those who smoke also have higher rates of alcohol and drug abuse.

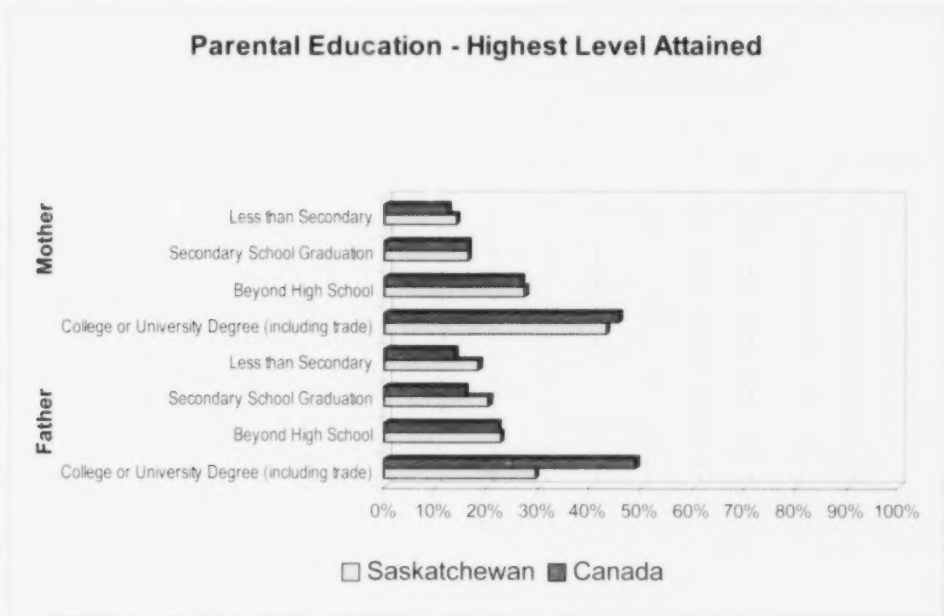
Depressed parents are usually withdrawn, tired, despondent and pessimistic about the future. These are not healthy influences as children raised by a depressed parent (particularly mothers) are more likely to have behaviour problems and poor cognitive development. Children in low-income households are at higher risk of having a depressed parent.

In the NLSCY, family functioning was measured by asking parents a number of questions about problem solving practices, expressive communication, decision-making and levels of acceptance. Families with low scores exhibit a high degree of dysfunctional behaviour. This kind of family environment increases the likelihood of childhood behaviour and emotional problems such as aggression and anxiety.

In the NLSCY, parents were asked how often they engaged in a number of positive parenting interactions with their children, such as praise, playing together, laughing together. Children whose parents who do not frequently engage in these types of positive interaction have a higher risk for poor motor and social development and the development of negative social behaviours as they grow up.

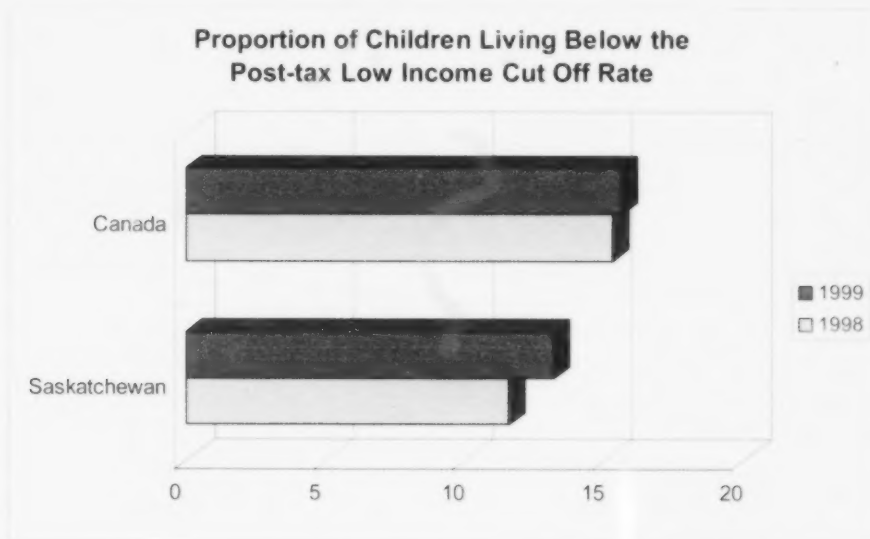
Adults who read to their children have a positive impact on children's educational outcomes. In general, the more frequently a child is read to, the more positive the benefits in vocabulary and reading comprehension during the earlier years of school.

Family-Related Indicators - Chart 1



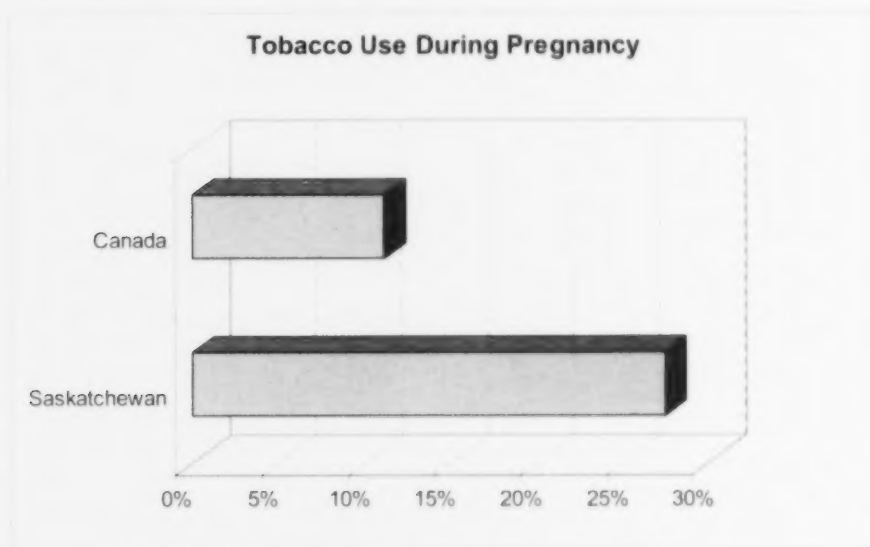
Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Family-Related Indicators - Chart 2



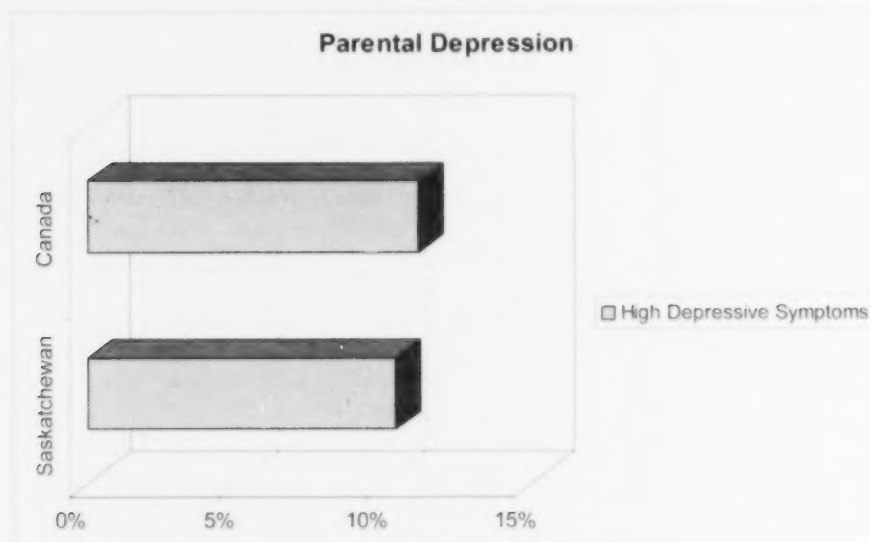
Source: Survey of Labour and Income Dynamics: Reference years 1998 and 1999.
Note: Population level Families with children 1 to 5 years of age (included).

Family-Related Indicators - Chart 3



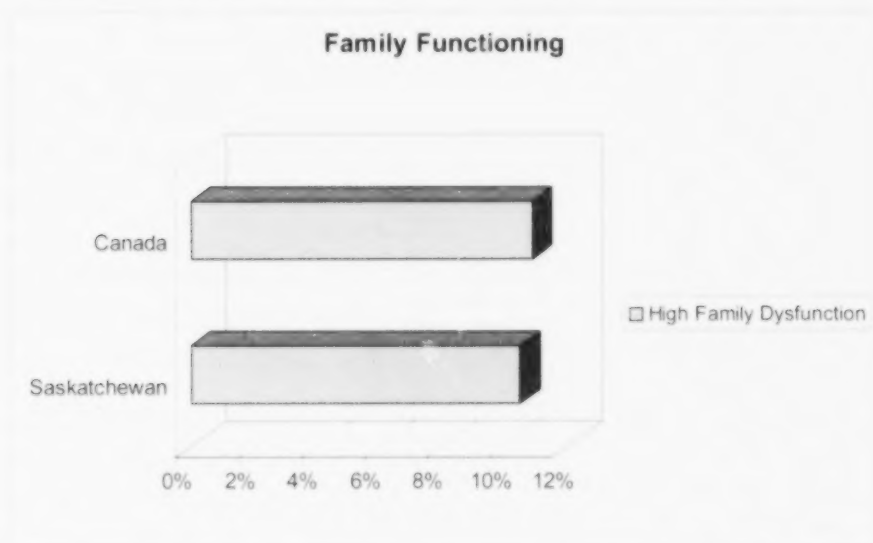
Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Family-Related Indicators - Chart 4



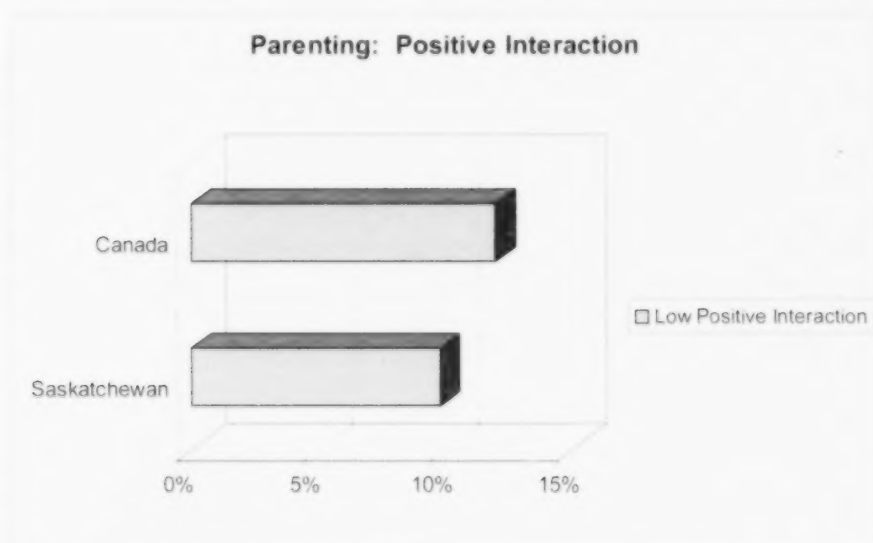
Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Family-Related Indicators - Chart 5



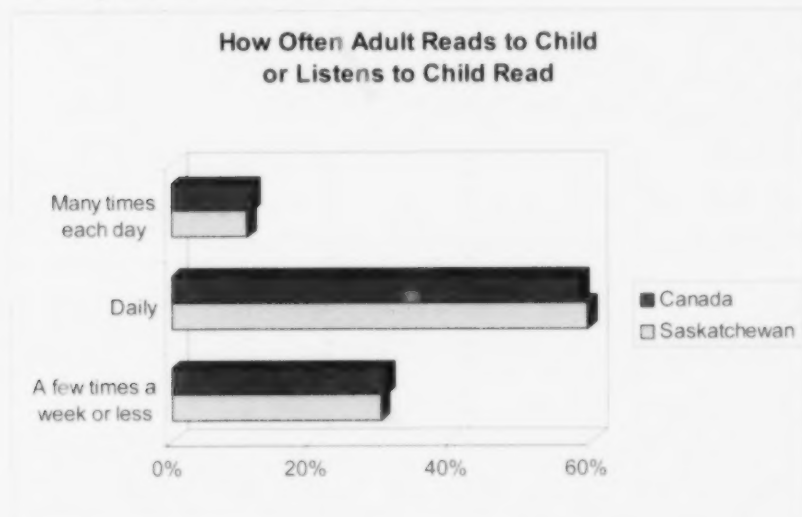
Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Family-Related Indicators - Chart 6



Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Family-Related Indicators - Chart 7



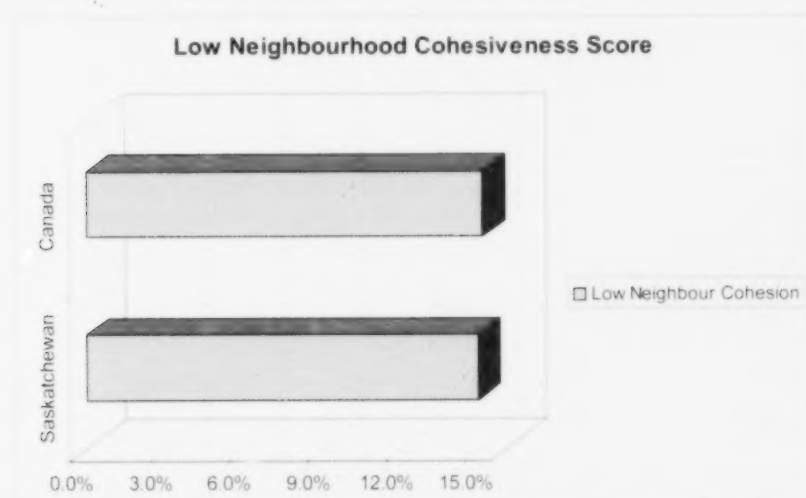
Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Community-Related Indicators

The neighbourhood cohesiveness score is based on perceptions of trust of neighbours, the presence of adults that children can look up to, cooperation of neighbours in dealing

with problems, watching out for children's safety and keeping an eye on other neighbours property when they are away. Children growing up in neighbourhoods with low levels of cohesiveness are less likely to be ready for school.

Community-Related Indicators - Chart 1



Source: NLSCY, Cycle 3 (1998/99), Master File, Parents Questionnaire; data presented are weighted.

Appendix C

Data Specifications

Description of Data Quality Guidelines for Presentation of Indicators Based on the National Longitudinal Survey of Children and Youth.

According to Statistics Canada, there are three different quality levels of the estimate (cell count) on the spreadsheets on which the preceding graphs are based: "acceptable" = sample size of 30 or more cases and a low coefficient of variation (between 0 - 16.5%). For this level, no warning is required.

"marginal" = sample size of 30 or more cases and high coefficient of variation (between 16.6% - 33.3%). For this level estimates **must** be flagged with an asterix (*) and be accompanied by the following warning: "While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it."

"unacceptable" = sample size of less than 30 cases or a very high coefficient of variation (in excess of 33.3%). For this level estimates **must** be flagged with a double asterix (**) and be accompanied by the following warning: "The following estimate does not meet Statistics Canada's quality standards for this statistical program. Conclusions based on these data will be unreliable and most likely invalid. These data and any consequent findings should not be published".

In the development of the common set of 11 indicators related specifically to child outcomes as well as the additional 12 indicators related to child and environmental (family and community) outcomes, data of unacceptable quality (i.e. cells with less than 30 cases) has already been suppressed.

Specifications for the Indicators of Child Well Being

Physical Health

Includes the following indicators:

- A. Healthy Birthweight (comprised of (i) Low Birthweight and (ii) High Birthweight)
- B. Immunization (comprised of (i) Invasive Meningococcal disease, (ii) Measles and (iii) Haemophilus Influenza B (hib) in children)
- C. Infant Mortality Rate
- D. Pre-term birth rate
- E. Breastfeeding (comprised of (i). prevalence of breastfeeding and (ii) duration of breastfeeding)..

A. Healthy Birthweight

(i) Low Birthweight

Measure:

Low Birthweight Rate

Definition:

The percentage of live births with weight greater than 500 grams and less than 2500 grams.

The low birthweight rate = (number of live births weighing >500 and < 2500g / number of all live births) * 100.

Source:

Canadian Vital Statistics – Birth Database (Statistics Canada).

Exclusions:

Births with unknown birth weight; births to non-Canadian residents, birth where residence of mother is unknown.

(ii) High Birthweight

Measure:

High Birthweight Rate

Definition:

The percentage of live births with a weight greater than 4000 grams.

The high birthweight rate =
(number of live births weighing >
4000g / number of all live births)
*100.

Source:

Canadian Vital Statistics – Birth
Database (Statistics Canada).

Exclusions:

Births with unknown birth weight;
births to non-Canadian residents.

B. Immunization

(i) Meningococcal Disease

Measure:

Invasive meningococcal disease
incidence rate

Definition:

The rate of new cases reported by
year for children 5 years of age
and younger.

Notes for Interpretation:

A new generation of very effective
protein conjugate vaccines is now
available against Group C disease
which can be given to infants as
young as two months of age. The
National Advisory Committee on
Immunization (NACI) recommends
three doses of this vaccine at two,
four and six months of age for
routine immunization.

The meningococcal incidence rate
= (number of cases / total
population ages 0-5) *100,000.

Source:

Division of Immunization and
Respiratory Diseases, Health
Canada

Exclusions:

N/A

(ii) Measles

Measure of Immunization and Respiratory
Diseases, Health Canada

(iii) Haemophilus Influenza b (Hib)
Disease in Children

Measure:

Haemophilus influenzae-b
(Invasive) disease incidence rate in
children <5years

Definition:

The rate of new cases reported by
year in children less than 5 years
of age.

Notes for Interpretation:

A confirmed case is defined as
invasive disease with laboratory
confirmation of infection in the
absence of recent immunization
with Hib-containing vaccine:
isolation of H. influenzae type b
from a normally sterile site or
epiglottitis in a person with
epiglottitis, or demonstration of H.
influenzae type b antigen in
cerebrospinal fluid. Invasive
disease includes meningitis,
bacteraemia, epiglottitis,
pneumonia, pericarditis, septic
arthritis, or empyema.

The Hib incidence rate = (number
of cases / total population ages 0-
4) *100,000.

C. Infant Mortality Rate

Measure:

Infant Mortality Rate

Definition:

The number of infants who die within
the first year of life per 1000 live births
The infant mortality rate = (number of
deaths of live born babies prior to the
364th day of completed life / number of
all live births) * 1000.

Source:

Canadian Vital Statistics, Birth and
Death Databases.

Exclusions: births to mothers not resident in Canada; births to mothers where the residence is unknown; deaths of infants where the residence is unknown.

D. Pre-term birth rate

Measure:

Pre-term birth rate

Definition:

The percentage of live births with a gestational age at birth of less than 37 completed weeks (less than 259 days).
The pre-term birth rate = (number of live births with gestational age at birth < 37 completed weeks / number of all live birth) * 100.

Source:

Canadian Vital Statistics – Birth Database (Statistics Canada).

Exclusions:

Births with unknown gestational age and gestational age less than 20 weeks; births to non-Canadian residents.

E. Breastfeeding

(i.) Prevalence of Breastfeeding

Measure:

Prevalence of Breastfeeding

Definition:

The proportion of children aged 0-3 years who are currently being or have ever been breastfed.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 4-5 years; children living in the Territories; children living on reserve; children living in institutions.

(ii.) Duration of Breastfeeding

Measure:

Duration of Breastfeeding

Definition:

The length of time children aged 0-3 years were breastfed.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 0-3 years currently being breastfed, children aged 4-5 years; children living in the Territories; children living on reserve; children living in institutions.

Early Development

Includes the following 6 indicators:

- A. Physical Health and Motor Development
- B. Emotional Health (comprised of (i) Emotional Problem/Anxiety and (ii) Hyperactivity)
- C. Social Knowledge and Competence (comprised of (i) Physical Aggression/Conduct Problems and (ii) Prosocial Behaviour)
- D. Language Skills

A. Physical Health and Motor Development

Measure:

Motor and Social Development (MSD)

Definition:

The proportion of children aged 0-3 years who have delayed, average and advanced levels of motor and social development. The Motor and Social Development scale consists of a set of 15 questions that measure dimensions of the motor, social and cognitive development of young children from birth through 3 years; the questions vary by age of the child. These questions are asked of the Person Most Knowledgeable (PMK) of the child¹.

The standardized score is being used for this indicator, in which the average score for the population is set at 100 with a standard deviation of 15. The standardized score takes account of the child's age and allows for comparisons of scores to be made across age groups. Based on the score: "delayed" = children scoring from 0-84 on the scale (one standard deviation below the mean and lower).

"average" = children scoring between 85-115 on the scale (a range from one standard deviation below the mean to one standard deviation above the mean).

"advanced" = children scoring 116+ on the scale (one standard deviation above the mean and higher).

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 4-5 years; children living in the Territories; children living on reserve; children living in institutions.

B. Emotional Health

(i) Emotional Problems/Anxiety

Measure:

Emotional Problem – Anxiety Score

Definition:

The proportion of children aged 2-5 years who exhibit high levels of emotional and/or anxiety problems. Emotional problems/anxiety is one of a number of behaviour scales examined in NLSCY. The purpose of the behaviour scales is to assess the extent of the presence/absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

Technical Notes:

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 0-1 years; children living in the Territories; children living on reserve; children living in institutions.

(ii) *Hyperactivity*

Measure:

Hyperactivity – Inattention Score

Definition:

The proportion of children aged 2-5 years who exhibit high levels of hyperactivity and/or inattention.

Notes for Interpretation:

Hyperactivity/inattention is one of a number of behaviour scales examined in the NLSCY. The purpose of the behaviour scales is to assess the extent of the presence/absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 0-1 years; children living in the Territories; children living on reserve; children living in institutions.

C. Social Knowledge and Competence

(i) *Physical Aggression/Conduct Problems*

Measure:

Physical Aggression Score

Definition:

The proportion of children aged 2-5 years who exhibit high levels of physical aggression, opposition and/or conduct disorder.

Notes for Interpretation:

Physical aggression is one of a number of behaviour scales examined in the NLSCY. The

purpose of the behaviour scales is to assess the extent of the presence/absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

Technical Notes:

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

(ii) *Prosocial Behaviour*

Measure:

Prosocial Behaviour Score

Definition:

The proportion of children aged 2-5 years who exhibit low levels of prosocial behaviour

Notes for Interpretation:

Prosocial behaviour is one of a number of behaviour scales examined in the NLSCY. The purpose of the behaviour scale is to assess the extent of the presence/absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do not represent professionally diagnosed problem behaviours.

Technical Notes:

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 0-1 years; children living in the Territories; children living on reserve; children living in institutions. Children whose *actual* age at the time of interview was one year have been removed from this estimate.

D. Language Skills

Measure:

Standard Score for PPVT-R (Peabody Picture and Vocabulary Test – Revised)

Definition:

The proportion of children aged 4-5 years who have delayed, average and advanced levels of receptive or hearing vocabulary. The PPVT-R is designed to measure receptive or hearing vocabulary in either English or French. The test is administered by the interviewer directly to children aged 4-5 years and to children aged 6 years and older who were not yet in grade 2 at the time of the interview. The PPVT-R is only administered to children whose PMK provided consent for the test to be administered to their child.

The standardized score is being used for this indicator, in which the average score for the population is set at 100 with a standard deviation of 15. This standardization was done by 2 month age groups. The standardized score takes account of the child's age and allows for comparisons of scores to be made across age groups. Based on the standardized score:

"delayed" = children scoring from 0-84 on the scale (one standard deviation below the mean and lower).

"average" = children scoring between 85-115 on the scale (a range from one standard deviation below the mean to one standard deviation above the mean).

"advanced" = children scoring 116+ on the scale (one standard deviation above the mean and higher).

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Direct Assessment

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 0-3 years; children aged 4-5 years for whom the PMK did not provide consent for the PPVT-R to be administered; children living in the Territories; children living on reserve; children living in institutions.

3. Safety and Security

Includes the following indicators:

- A. Injury Mortality Rate
- B. Injury Hospitalization Rate

A. Injury Mortality Rate

Measure:

Injury Mortality Rate

Definition:

The proportion of children aged 0-5 years who die as a result of an injury. Data on the injury mortality rate includes the following types of injuries:

- Motor vehicle traffic crashes
- Falls

- Other unintentional
- Self-inflicted
- Assault
- Other

The injury death rate = (number of deaths resulting from an injury/total population)*100,000.

Source:

Canadian Vital Statistics – Mortality Database (Statistics Canada).

Exclusions:

Non-Canadian residents.

B. Injury Hospitalization Rate

Measure:

Injury Hospitalization Rate

Definition:

The proportion of children aged 0-5 years who are hospitalized for treatment of injuries.

Data on the injury hospitalization includes the following types of injuries:

- Motor vehicle traffic crashes
- Falls
- Other unintentional
- Self-inflicted
- Assault
- Other

The injury hospitalization rate = (number of hospitalizations for treatment of injuries/total population)*100,000.

Source:

Canadian Institute for Health Information (CIHI) – hospital records

1. Family-Related Indicators

Includes the following:

- A. Parental Education (comprised of (i). mother's highest level of education and (ii) father's highest level of education)
- B. Level of Income (comprised of (i). pre-tax LICO, (ii) post-tax LICO and (iii) post-tax LIM)
- C. Parental Health – Parental Depression

- D. Parental Health – Tobacco Use During Pregnancy
- E. Family Functioning
- F. Positive Parenting
- G. Reading by Adult

A. Parental Education

(i.) Mother's Highest Level of Education

Measure:

Mother's highest level of education

Definition:

The highest level of education attained by the mother of children aged 0-5 years.

Highest level of education has been disaggregated into 4 categories:

- Less than secondary school
- Secondary school graduation
- Beyond secondary school (but has not achieved postsecondary school diploma/degree)
- College or university degree (including trade).

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster mother; children living in the Territories; children living on reserve; children living in institutions.

(ii.) Father's Highest Level of Education

Measure:

Father's highest level of education

Definition:

The highest level of education attained by the father of children aged 0-5 years.

Highest level of education has been disaggregated into 4 categories:

- Less than secondary school
- Secondary school graduation
- Beyond secondary school (but has not achieved postsecondary school diploma/degree)
- College or university degree (including trade).

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire
While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster father; children living in the Territories; children living on reserve; children living in institutions.

B. Level of Income

(i.) Pre-Tax Low-Income Cut-Off (LICO)

Measure:

Pre-Tax LICO Rate

Definition:

The proportion of children aged 0-5 years living below the pre-tax LICO.

The Low-Income Cut-Off is a relative measure based on the percent of income spent on basic needs by an average family.

The pre-tax LICO is set according to the proportion of annual pre-tax income (total income including government transfers before the deduction of income taxes) spent on basic needs (food, clothing and shelter). A household that spends 20% more on basic needs than the average family is considered to be living below the low-income cut-off. The LICO is adjusted for location and family size.

Source:

Survey of Labour and Income Dynamics (SLID) – Statistics Canada, Reference Years 1998 and 1999.

Exclusions:

Children living in the Territories.

(ii.) Post-Tax Low-Income Cut-Off (LICO)

Measure:

Post-Tax LICO Rate

Definition:

The proportion of children aged 0-5 years living below the post-tax LICO.

Notes for Interpretation:

The Low-Income Cut-Off is a relative measure based on the percent of income spent on basic needs by an average family. The post-tax LICO is set according to the proportion of annual post tax income (total income after the deduction of income taxes) spent on basic needs (food, clothing and shelter). A household that spends 20% more on basic needs than the average family is considered to be living below the low-income cut-off. The LICO is adjusted for location and family size.

Source:

Survey of Labour and Income Dynamics (SLID) – Statistics Canada, Reference Years 1998 and 1999.

Exclusions:

Children living in the Territories.

C. Parental Health – Parental Depression

Measure:

Parental Depression

Definition:

The proportion of children aged 0-5 years whose PMK² exhibits high symptoms of depression.

The Depression scale in the NLSCY represents a condensed version of the Depression Rating Scale (CES-D). This scale measures the occurrence and severity of symptoms associated with depression in the public at large and does not represent the occurrence of clinically diagnosed depression. The scale ranges in value from 0-36 with high scores indicating the presence of depressive symptoms. This scale is administered to the person most knowledgeable (PMK) about the child.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

D. Parental Health – Tobacco Use During Pregnancy

Measure:

Smoking During Pregnancy

Definition:

The proportion of children aged 0-1 years whose mother smoked during her pregnancy with the child.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 2-5 years; children living in the Territories; children living on reserve; children living in institutions.

E. Family Functioning

Measure:

Family Functioning

Definition:

The proportion of children aged 0-5 years in families with high levels of dysfunction.

The family functioning scale provides a global assessment of family functioning (including problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control) and indicates the quality of relationships between family members. This scale is administered to either the person most knowledgeable (PMK) about the child or the spouse/partner. The scale ranges in value from 0-36 with higher scores indicating family dysfunction. The scale does not reflect a clinical diagnosis.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

F. Positive Parenting

Measure:

Positive Interaction

Definition:

The proportion of children aged 0-5 years whose parents exhibit low positive interaction with the child.

Positive interaction is a parenting style that is captured in the NLSCY. The purpose of the parenting scales is to measure certain parental behaviours. The scale ranges in value from 0-20, with high scores indicating positive interaction with the child. The questions assessing parenting styles were administered to the person most knowledgeable (PMK) about the child or spouse/partner of the PMK.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

The frequency that an adult reads to child/listens to child read has been aggregated into the following categories:

- A few times per week or less
- Daily
- Many times each day.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children aged 0-1 year of age; children living in the Territories; children living on reserve; children living in institutions.

2. Community—Related Indicators

A. Neighbourhood Satisfaction, Safety and Cohesion

A. Neighbourhood Satisfaction, Safety and Cohesion

Measure:

Neighbourhood Cohesion

Definition:

The proportion of children aged 0-5 living in neighbourhoods with low neighbourhood cohesion, as judged by the PMK

The purpose of the neighbourhood scales is to assess the extent of the presence/absence of certain neighbourhood characteristics. In particular, the neighbourhood cohesion scale can be used to measure the social unity of a neighbourhood (the extent to which the person most knowledgeable

G. Reading by Adult

Measure:

Reading by Adult

Definition:

Distribution of children aged 2-5 years by how often an adult reads to the child or listens to the child read.

This indicator refers to the exposure of the child to reading activities with a parent or another adult. Therefore, this indicator should not be interpreted to refer specifically to parent-child interactions.

(PMK) about the child feels that there is cohesion in the neighbourhood). The scale ranges in value from 0-15 with higher scores indicating neighbourhood cohesion in the child's neighbourhood.

Source:

National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998/99), Parent Questionnaire

While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.

Exclusions:

Children living in the Territories; children living on reserve; children living in institutions.

(Footnotes)

¹ DEFINITION: PMK (Person Most Knowledgeable) in the NLSCY

In the NLSCY, a question was asked about who in the household was the person most knowledgeable (PMK) about the child participating in the survey. The intention was that the PMK, in most cases the mother, would provide information for all selected children in the household, as well as the sociodemographic information about herself and her spouse. The latter information was used to describe the socioeconomic situation of the child's family. Only one PMK was selected per household.

² For a definition of PMK please see the indicator "Physical Health and Motor Development"





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